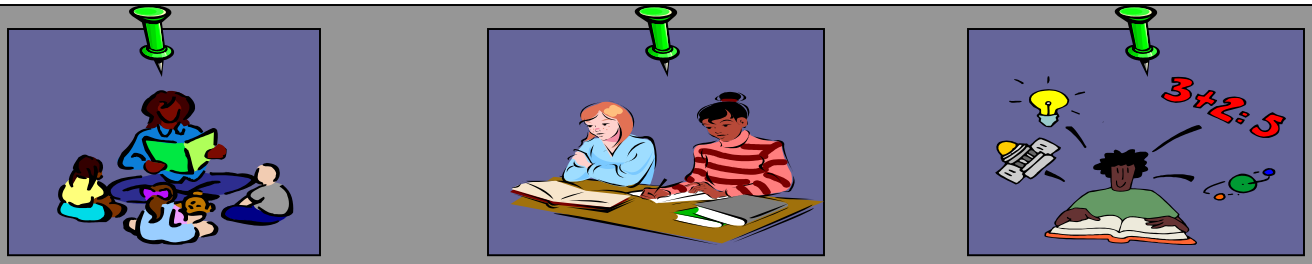
Appendix 4

District of Columbia

Department of Mental Health

Resilience and Recovery



School Mental Health Program

Reducing Barriers to Learning

Levels of Intervention

Primary Prevention: Intervention strategies for all students to PREVENT mental health, behavioral, and social issues before they occur. *Services include school-wide interventions, classroom-based interventions, and mental health promotion activities for example, prevention of substance abuse, sexual abuse, and violence; anger management.*

Early Intervention Services: These services are provided at the first occurrence of emotional, behavioral, or social concerns. *Services include psycho-educational sessions, social skills, anger management, and various support groups.*

Treatment Services: Treatment is provided for students with a variety of problems, including depression, substance abuse, disruptive behavior, anxiety, peer relational problems, grief and loss, trauma, and family issues. *Services include individual, family, and group counseling.*

Crisis Services: Interventions are provided for urgent situations and needs. *Services include crisis debriefing, grief counseling, and psychiatric referrals.*

Parent/Family Support: Educational, supportive, and treatment services are provided for families.

DC Public Schools

Benning Elementary School
Charles Young Elementary School
Davis Elementary School
Emery Elementary School
Fletcher-Johnson Educational Center
Gibbs Elementary School
LaSalle Elementary School
Myrtilla Miner Elementary School
River Terrace Elementary School
RK Webb Elementary School
Thurgood Marshall School
Turner Elementary School
Wheatley Elementary School
Browne Junior High School
Ron Brown Middle School
Eliot Junior High School
Spingarn High School
Terrell Junior High School
Kelly Miller Middle School
Garnet Patterson Middle School

Charter Schools

Booker T. Washington Charter School
Cesar Chavez Public Charter High School
Children's Studio Elementary School
Friendship Edison Collegiate Academy
Maya Angelou Public Charter School
Meridian Public Charter School
Options Public Charter School
SAIL Public Charter School
SEED School of Washington, DC

For more information about the School Mental Health Program contact Dr. Olga Acosta Price at 202-671-3107 or by Email at olga.acosta@dc.gov

Appendix 4

SCHOOL MENTAL HEALTH PROGRAM, 2000-2005

The D.C. School Mental Health Program (SMHP), a school-based program out of the Child and Youth Division in the Department of Mental Health, offers a comprehensive array of services to children and youth enrolled in the public schools and their families. The SMHP assigns one qualified mental health provider to selected public schools and public charter schools, working collaboratively with school-hired mental health providers to conduct prevention, early intervention, and less intensive outpatient treatment for students and their families. Services include prevention workshops, early intervention services, mental health screening, focused behavioral and emotional assessments, treatment (individual, family, and group counseling), consultation, training, and limited case management. National studies have supported the implementation of this type of service delivery model for youth and families, and now local evaluation further supports the utilization of school-based interventions for use with residents in the D.C. community.

Utilization of Services

Students, families, and school staff have demonstrated increased utilization of the variety of services offered through the SMHP in approximately 30 public and public charter schools. In the majority of categories, the number of services delivered through the SMHP have increased, except in areas where a change in program emphasis could account for a decrease (e.g., individual sessions decrease but prevention contacts increase). During the last school year (2004-2005), 458 students were formally referred and seen for a variety of behavioral or emotional concerns through the SMHP, 2544 were seen as 'walk-ins', and 1342 conflict resolution sessions were completed, with an equivalent number of male and female students participating in the school-based programs. Individual counseling (4908), group counseling (980), and family counseling (173) sessions have been conducted throughout the year and 324 home visits were made. Consultation to parents (1510), teachers and school staff (4446), classroom observations (1366), and staff development/professional in-services (116) were

provided. While the number of schools in the program has increased, the numbers of reported school-based crises have decreased over the last three years.

Data indicates that referrals to the SMHP were primarily received from administrators when the program was first developed, however teachers, families, and student self-referrals now account for the top three referral sources into the program. The majority of referrals to the program over the past three years have been for disruptive behavior, depressive symptoms, poor academic performance, poor peer relations, family conflicts, and hyperactivity.

Satisfaction with Services

Children and youth who have participated in the SMHP reported very high levels of satisfaction with services offered. In 2004, over 90% of the students that completed the Child Satisfaction Survey felt positively about their therapeutic experience that year and reported they would bring a friend if they were experiencing problems, while over 93% indicated they would return themselves to see the SMHP clinician if needed. Over 86% of the youth felt positively about their experience with services that year as indicated in the Youth Satisfaction Survey, and 70% reported their experience with the SMHP clinician was "excellent". The majority of the school principals and administrators that completed the School Mental Health Rating Form (over 90%), reported that SMHP clinicians assigned to their respective schools were knowledgeable, built relationships with family members, worked collaboratively with other school staff, and worked collaboratively with the students to build appropriate mental health services for them. All school leaders (100%) agreed that they wanted the SMHP clinician to return to their school the next year.

At the end of the following year (June 2005), the number of satisfaction surveys returned to the program increased (for children from 121 to 220 satisfaction forms and for youth from 205 to 269 satisfaction forms) and indicated even more favorable satisfaction results from consumers. Over 99% of the 220 children completing the Child Satisfaction Survey indicated that they liked seeing their counselor, over 98% reported feeling better, and 99% stated that they would go back to see their counselor if they needed help. Results of the youth satisfaction surveys for that year also indicated improvement in program satisfaction. Of the 269 youth that completed the satisfaction survey, a majority reported that SMHP clinicians were more likely to help them make better decisions (90% agreed/strongly agreed), deal effectively with stress (83%

agreed/strongly agreed), and feel better after talking (87% agreed/strongly agreed). New satisfaction measures were created to gauge parent/caregiver and teacher satisfaction levels and were implemented during the 2004-2005 school year. From the 43 parent/guardian satisfaction surveys returned parents/guardians reported that there were demonstrable positive outcomes as a result of working with the SMHP clinician, and a significant majority of the parents/guardians who returned surveys (98%) indicated they would recommend the SMHP clinician to another parent/guardian. All of the parents/guardians in the sample stated that they would feel comfortable talking with the clinician again if they needed help (100% agreed/strongly agreed). The 147 teachers/staff that completed surveys reported that they felt the SMHP clinician was knowledgeable about mental health issues (98% agreed/strongly agreed), worked collaboratively with school staff (95%), and provided effective strategies for working with students with behavioral concerns (95%). In addition, the vast majority (99%) indicated they would recommend the clinician to other teachers. The administrator satisfaction surveys completed in 2004-2005 indicated that school principals continued to feel very positively about the SMHP. Similar to the previous year, all school administrators (100% agreed/strongly agreed) believed the SMHP clinician to be knowledgeable about mental health issues relevant to students enrolled at their school and reported that SMHP clinicians worked collaboratively with school staff, students, and parents/guardians to develop/strengthen the mental health program at the school. These results indicate that through programmatic adjustments and efforts to expand the program, the quality of services delivered did not suffer.

Outcomes

A number of the school- and youth-level outcomes that have been noted after the first five years have been developmental in that the program has grown in size and scope during this period of time. Although quantitative data that is needed to fully evaluate the program is not available, the majority of school principals/leaders with a SMHP believed that the number of fights between students had lessened, the number of students repeating a grade had decreased, and disciplinary referrals had declined. Further, they reported that their school appeared safer, more organized, and that staff seemed more content with the school climate from one year to the next.

There were a number of challenges with obtaining consistent school-level data, but efforts are underway to systematize data collection and sharing. Although changes in truancy rates or attendance could not be seen or associated with the SMHP, preliminary results strongly suggest a possible relationship between the SMHP and decreases in suspensions and reductions in referrals to special education. Analyses performed indicate that a pattern has emerged suggesting a reduction in student suspensions is evident when comparing data for the last several years. Although no conclusions could be drawn about the rates of referral for students eligible for emotional disturbance due to the amount of missing data in the special education tracking system, changes were noted in the number of referrals to special education in general across schools when comparing several years worth of data. Analyses indicated, with 95% confidence, that there are statistically significant differences in referrals to special education between SY 2002 and SY 2004, as well as SY 2003 and SY 2004 (at the .05 level of significance). Although referrals to special education for the entire 2004-2005 school year are not yet known, these statistics are promising in demonstrating a possible reduction in the general number of referrals to special education for schools with a SMHP.

Data collected on the effects of primary prevention interventions offered through the SMHP (sexual abuse prevention program, peer sexual harassment training, school-wide behavior modification) indicate important changes in behavior, attitudes, and skills are observed among children and youth. Specifically, children participating in the Good Touch/Bad Touch program learned new information about sexual abuse identification and prevention across all relevant grade levels as demonstrated through pre- and post-testing. Post-test results from the RESPECT program document shifts in empathy that correspond to normative misperceptions that will eventually help SMHP clinicians address the cultural risk factors that will increase the likelihood of success for other prevention and early intervention programs. A school-wide behavior management program conducted in a junior high school demonstrated significant improvements in targeted behaviors across all grades.

During the 2004-2005 academic year, a pilot study was launched for students age seven and older seeking individual, group, or family therapy to determine the impact of the SMHP on various clinical areas of functioning. Students who agreed to participate in this evaluation were provided a standardized pre and post-assessment. The areas of focus for the clinical program evaluation were similar to the most frequently reported major presenting problems from previous

years: depression, disruptive behavior, anger, and aggression. There were thirty-three (33) children between the ages of six and twelve who completed the assessments. Seventeen of them were male and sixteen were female. The clinical study found that with regards to children and their depression scores, there was a decrease in individual scores from pre- to post test, however, this change was not significant. For those who were considered to have clinically significant scores, their level of depression also decreased. Again, the result was not statistically significant. Over the course of treatment there was a decrease in the individual level of anger among children. This result was also seen among those classified as having "clinically significant" levels of anger. However, neither of these results was found to be statistically significant.

Although a number of promising results were provided in this report, there are a number of considerations and recommendations that need to be addressed if the expansion and evaluation of the SMHP are to be achieved responsibly. First, there are extremely limited resources dedicated for evaluation of the SMHP within DMH. If funding is diversified and as requirements for evaluation increase, the pressure for data and outcomes will intensify. To date DMH has not had available funds or a position(s) dedicated solely for the coordination and evaluation of the SMHP, to an information system, or to basic equipment or tools (i.e., assessment tools, computers, etc.). Furthermore, the collection of data varies greatly school by school, posing a severe restriction on the efficiency with which such a task could be completed, particularly as we look towards expanding across the entire public school system in D.C. A number of different individuals, offices, and departments have authority over data elements important to the evaluation of the SMHP. Therefore, negotiating data sharing and developing memorandums of understanding between agencies is of primary concern; without data there can be no effective program evaluation.

While the enthusiasm, innovation and creativity of the SMHP in large part drives the program's success, sufficient financial support provides the foundational element without which the program would falter. DMH has dedicated both financial and intellectual resources to the program, both of which must be maintained to assure the program's viability for the future. Yet, the most important next step in the evolution of the SMHP involves strategic planning for the sustainability of this program through braided funding involving school systems (DCPS and the public charter schools), community mental health, universities, federal financing, state agency support, and foundations.

This report clearly shows that youth and their families are likely to utilize services that are accessible, integrated within systems familiar to students and families, staffed by highly trained and supervised professionals working within structured programs, and based on sound theory. These findings are also consistent with a large body of research that has demonstrated that a focus on strengthening systems that surround a child and family is more effective than solely attending to the individual characteristics of a child or youth that might contribute to their condition. As systems that surround a child are strengthened, dysfunctional behaviors, emotional outbursts, and social concerns are often ameliorated or eliminated. Therefore, programs that take a simplistic and narrow approach to addressing mental health problems are ultimately doing a disservice to the individuals or families they are trying to serve. Just as we believe it is the right of every child to have access to effective classroom instruction, adequate health care and a positive school experience with activities and opportunities for growth and skill development, we believe this report demonstrates the right of every child, youth, and family living in D.C. to have access to comprehensive, effective, integrated, and seamless mental health support that is available at the first sign of concern or worry, administered by a caring, qualified, and well-trained professional. Building this program across our whole community will help our children reach their full potential and be able to live happier, healthier lives.

Return